Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PINE CREEK MEDICAL CENTER
9032 HARRY HINES BLVD
DALLAS TX 75235

Carrier's Austin Representative Box
Box Number 19

MFDR Date Received
October 2, 2009

Respondent Name
ZURICH AMERICAN INSURANCE COMPANY

MFDR Tracking Number
M4-10-0844-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The disputed fees should be paid in accordance with DWC Rule 134.600. We are requesting 108% of IPPS and separate reimbursement for the implant devices in accordance with TDI-DWC §134.404. Hospital Facility Fee Guideline – Inpatient. According to TDI-DWC §134.600, Preauthorization, Concurrent Review, and Voluntary Certification of Health Care, the carrier is liable for all reasonable and necessary medical costs relating to the heath care. TDI/DWC CCH dated May 15, 2008, determined that the compensable injury includes a 2 mm disc protrusion at L5-S1. Carrier was ordered to pay benefits in accordance with the decision, the Texas Workers' Compensation Act, and the Commissioner's Rules."

Amount in Dispute: $48,514.52

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier has not paid it because of extent of injury issues as Provider failed to link its services to the compensable injury. Previously, the DWC determined in 2008 that the compensable injury includes a 2mm disc protrusion at L5-S1 but does not include L4-L5 bilateral radiculopathy or L5-S1 left radiculopathy. A Benefit Review Conference scheduled for October 21, 2009 (on the extent of injury dispute, if a dispute even exists in this matter. That conference has resulted in a contested case hearing scheduled on December 16, 2009. Until we know the outcome of the CCH, it is difficult for the carrier to assert a final position."

Response Submitted by: Flahive Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 30, 2008 Through October 31, 2008	Inpatient Hospital Surgical Services	$48,514.52	$48,514.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."
   (3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).
4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."
5. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 17, 2008
   - 219 –Based on extent of injury

   Explanation of benefits dated July 1, 2009
   - 219 –Based on extent of injury

Issues

1. The carrier has addressed the issue of compensability/extent of injury for the claim. Has the compensability/extent of injury issue been adjudicated?
2. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
3. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
4. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The respondent denied disputed services with reason code 219 – "Based on extent of injury." A Contested Case Hearing was held on April 23, 2008 to address the extent of injury issues regarding the injured worker's compensable injury. The decision held, in pertinent part, that, "The February 5, 2007 compensable injury includes a 2mm disc protrusion at L5-S1. The compensable injury does not include L4-L5 bilateral radiculopathy or L5-S1 left radiculopathy." A subsequent Contested Case Hearing was held on December 16, 2009 to address the extent of injury issue regarding the injured worker's lumbar spinal stenosis. The decision held, in pertinent part, that, "The compensable injury of February 5, 2007 does not extend to include lumbar spinal stenosis." The extent of injury issues raised by the carrier have been finally adjudicated. The provider billed with 722.10 – Displacement Lumbar Intervert Disc without Myelopathy; 493.90 – Asthma, Unspecified; and 305.1 – Nondependent Tobacco Use Disorder. The Division finds that the extent of injury issue has been resolved; therefore, the services rendered to treat lumbar strain and disc protrusion at L5-S1 related to the compensable injury will be reviewed per applicable Division rules and fee guidelines.

2. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
3. Review of the submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g). The Division finds the total allowable for implantables billed under revenue code 455 is:

Description of Implant per Itemized Statement	Quantity	Invoice Cost
Isotis Putty, 10cc	1	$1,550.00
Screw, 6.5 x 45mm	2	1,100.00/each
Screw, 7.5 x 35mm	2	$1,100.00/each
Osteosponge Strip	1	$1,495.00
Locking Cap	4	$343.00/each
Rod, 5.5 x35mm	2	No Invoice Submitted
Rod, 5.5 x35mm	2	$387.00/each
Titan Cage	1	$6,200.00
Symphony Graft	1	$315.00
Aspiration Needle, 3 hole	1	$210.00

4. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 455 is $30,029.14. This amount multiplied by 108% is $32,431.47.The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $16,316.00. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,631.60. The total maximum allowable reimbursement (MAR) is therefore $50,379.07. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount of $50,379.07. The requestor is seeking $48,514.52. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $48,514.52.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $48,514.52 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	August 3, 2012 Date
Signature	Medical Fee Dispute Resolution Manager	August 3, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.